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Severe medically unexplained physical symptoms in the sick-listed occupational health population

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Summary

In the introduction, in **Chapter 1**, the results of the different studies showed that medically unexplained physical symptoms (MUPS) are quite common in sick-listed employees, but in the working population there is a lower prevalence of MUPS. Various studies have focused on the associations between fatigue and sickness absence and reported on the prevalence of MUPS in employees with lasting disabilities. The prevalence of MUPS in general samples of sick-listed employees has not yet been investigated. Therefore, in contrast to primary care, it is not known which impact MUPS have on health-related functioning and the duration of sickness absence, or their associations with psychiatric co-morbidity, and the consultation load of occupational health physicians (OHPs). Furthermore, we do not know whether OHPs experience difficulties in the consultations, what these difficulties are, what diagnoses they make, their needs for adjustment with general practitioners (GPs) and for the involvement of a psychologist or a psychiatrist. The main goal of this thesis was to answer these research questions in a representative sample of sick-listed employees in the Netherlands. **Chapters 2, 3, and 4** describe the results of our cross-sectional study, and **Chapter 5** presents the results of a 2-year follow-up on the outcomes of duration of sickness absence, health-related discharge and lasting disabilities.

Long-lasting forms of MUPS are regarded by psychiatrists as psychiatric disorders in the form of somatoform disorders, and are often associated with psychiatric co-morbidity. Cognitive Behavioral Treatment (CBT) and psychiatric consultation are effective methods of treatment, according to the results of various reviews. In this thesis we studied the effect of psychiatric consultation on sickness absence in sick-listed employees with mental disorders (**Chapter 6**) in a randomized clinical trial (RCT), and performed a systematic review of the effect of psychiatric consultation letters (CLs) on patients with MUPS, in terms of medical consumption and physical functioning (**Chapter 7**).

Chapter 2 describes the baseline characteristics of our sample of 489 sick-listed employees (response 60%). In this population with a mean of 123 days of sick leave, the prevalence of severe MUPS, operationalised as a score on the Patient Health Questionnaire (PHQ)-15 of 15 or higher (PHQ+ group), was 15.1%. We dichotomized our data to a PHQ 15+ group and a PHQ 15- group (score less than 15, indicating medium, low and minimal MUPS scores). Severe MUPS was associated with 4-6 times more psychiatric co-morbidity, and higher levels of health anxiety and distress, compared to the PHQ 15-group. Employees with severe MUPS were more impaired on all aspects of health-related functioning. One co-morbid psychiatric disorder added to the functional impairment which employees with severe MUPS experienced, but more than one co-morbid psychiatric disorder did

not increase functional impairment in these employees. OHPs diagnosed employees with severe MUPS as 'somatisers' as often as employees with less severe forms of MUPS, indicating that OHPs use another concept for somatisation than used in literature. In two thirds of the employees with severe MUPS, the OHP's diagnosis was a mental disorder. In two thirds of the cases employees attributed their physical symptoms either to mental causes or to both mental and physical causes. The results show that many sick-listed employees with mental disorders are severely bothered by their MUPS, and recognize the possibility of a relationship between their physical symptoms and mental causes. Employees with multiple psychiatric co-morbidity attributed the symptoms more often to physical causes, but the OHPs more often attributed them to mental causes. Therefore, in case of severe MUPS with multiple psychiatric co-morbidity there is an increasing risk of conflict in management and communication between OHP and employee. The results of Chapter 2 indicate that OHPs need more training to recognize severe MUPS and its implications. Validated questionnaires as the PHQ-15 and the Four-Dimensional Symptom Questionnaire (4DSQ) could be useful tools for the OHP.

Chapter 3 focuses on the difficulties OHPs encounter in their consultations with employees with severe MUPS. In contrast to our hypothesis, we found that OHPs did not need extra time for sick-listed employees with severe MUPS, compared to employees with less severe forms of MUPS. We also found that they had no extra difficulties in their consultation with regard to the advice they gave about limitations and possibilities, return to work (RTW), or communication with the employee and the employer. The OHPs only experienced difficulties concerning the treatment provided by treating physicians and their communication with the GPs. More important than the difficulties, the OHPs expressed certain needs in their management of employees with severe MUPS: the expertise of a psychiatrist and a psychologist, and adjustment with the GP. These needs were mainly for diagnostic purposes. The results indicate, on the one hand that OHPs manage sick-listed employees with severe MUPS no differently from other employees, but on the other hand, the results in Chapter 2 indicate that OHPs do not recognize the implication of severe MUPS with respect to psychiatric co-morbidity, health anxiety, distress and functioning. Their needs, especially for additional diagnostic expertise and adjustment with the GPs confirm this picture. We recommend that OHPs should take more time to establish a diagnosis, to explain more clearly to employees with severe MUPS, to improve their communication with GPs, and to achieve easier access to the expertise of psychiatrists, psychologists and multidisciplinary treatment.

In **Chapter 4** we investigated what the sick-listed employees experience as stressors. Input was the open question in the PHQ in which the employees

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could indicate what bothered them most. Based on the literature, our hypothesis was that employees with severe MUPS would be bothered more by their medical problems (treatment, referrals for physical symptoms) and mental symptoms, work-related factors, and factors associated with their RTW process, than employees with less severe forms of MUPS. Our results show that the employees with severe MUPS are bothered most by their medical problems, their mental symptoms, and their private problems, whereas employees with less severe MUPS or no MUPS are bothered most by their medical problems, work-related problems, and problems with their RTW process. Significant differences between the two groups concerned the mental problems (23.5% in the severe MUPS group versus 8.9%), financial problems (5.9% versus 1.1%) and reporting no problems (0.0 versus 6.5%). These results imply that these employees are bothered most by their symptoms and the treatment of their symptoms. OHPs should be beware of these attributions made by employees, which in sick-listed employees with severe MUPS are less often related to work, private problems and the RTW process than was expected.

Chapter 5 describes the longitudinal study with a 2-year follow-up of the 489 sick-listed employees on the outcomes of duration of sickness absence, health-related job loss (HRJL) and lasting disabilities. Employees with severe MUPS had a median of 78 days longer duration of sickness absence than employees with medium, low and minimal MUPS scores. They more often remained disabled, and were more often discharged, especially due to problems in the employee-employer relationship. These unfavorable long-term outcomes for sick-listed employees with severe MUPS are important arguments for the early recognition of severe MUPS by the OHP, and for extra interventions if the RTW process is hampered.

We found that severe MUPS, health anxiety, and older age were independent determinants of a longer duration of sickness absence. Severe MUPS and health anxiety should therefore be recognized by the OHP. Older age is known to be associated with more physical symptoms and less mental symptoms, more physical attributions, and a longer duration of RTW in cases of depression. Our findings apply to this picture.

Group practices had a mixed contribution, and the group practice with many middle-sized non-profit organizations contributed to a longer duration of sickness absence. The group practice with large central government organizations and more centralized occupational health care contributed to a shorter duration of sickness absence.



In sick-listed employees our data showed that in addition to severe MUPS, health anxiety, older age and certain work characteristics (including the level of occupational health care) should be recognized as prognostic factors.

We performed a RCT in sick-listed employees with common mental disorders (CMDs) to evaluate the effectiveness of psychiatric consultation on the duration of sickness absence, symptoms, and quality of life. This is described in **Chapter 6**. The intervention consisted of a psychiatric consultation with advice from the psychiatrist to the employee, and a consultation letter describing the psychiatrist's diagnosis and advice with regard to the treatment and the RTW process in view of the diagnosed disorder. The consultation followed after the participating OHPs were trained in the diagnosis and treatment of common mental disorders. Trends were found for improvement in terms of symptoms and quality of life. The time until RTW in the intervention group was shorter at the 3-months follow-up, and survival analysis showed a trend towards a 68-day shorter duration of RTW in the intervention group.

At baseline the mean duration of 144 days of sickness absence was relatively long, and due to the inclusion of insufficient numbers of employees the study did not have enough power to show clearer results.

The results did, however, show that long-term sick-listed employees with CMDs have high percentages of psychiatric morbidity (77% comorbidity of depressive and anxiety disorder, 58% somatoform disorder). They also showed that the intervention is feasible in occupational health care, and could be further developed. Studies with shorter inclusion periods, and especially more power, are needed to inventarise the effects.

In a systematic review of 6 RCTs, described in **Chapter 7**, we assessed the effectiveness of a CL provided to GPs or OHPs for the care in primary care or occupational health care for patients with MUPS, with regard to medical consumption, medical costs, functioning and RTW. Unfortunately none of the studies focused on occupational health care populations, and none of the RCT used RTW as an outcome. Four of the six RCTs, with a total of 267 patients included, assessed the effectiveness of CLs and two RCTs, with a total of 182 patients included, assessed the effectiveness of psychiatric consultation in the presence of the patient (in one RCT the GP was also present during the consultation and training the GPs in diagnostics and treatment was part of the intervention).

We found strong evidence that CLs are effective in the care that primary care physicians provide for patients with MUPS, in terms of medical costs and physical functioning, and limited evidence with regard to the outcome

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of inpatient medical consumption in the form of hospital days. We found limited evidence that a joint consultation (with a patient by a psychiatrist in the presence of the physician), together with the provision of a CL, results in reduced severity of somatisation symptoms, reduced medical consumption, and improved social functioning. Our review shows that the diagnosis of MUPS and the advices in the CL with regard to communication and care management are effective. The four studies with the CL intervention were carried out in the last two decades of the 20th century and a RCT has been performed in which the combination of CL and CBT was found to be more effective than CL alone. The evidence indicates that collaborative care including support for the OHP in the form of training and the possibility to consult a psychiatrist, could improve the management of employees with MUPS.

In **Chapter 8** we discuss the most important findings of the studies described in this thesis. The methodological strengths and limitations of the cross-sectional studies, on the one hand and the RCT and the systematic review on the other hand, are discussed. The implications for practice and the recommendations follow-up research are explained.

Our general conclusions are that severe MUPS are important in occupational health care, because of their prevalence, their impact on health-related functioning, the resulting duration of sickness absence, HRLJ, and lasting disabilities. Our data also indicate that OHPs have diagnostic needs, but that they manage the MUPS, in two thirds of the cases as a mental disorder, and in one third of the cases as a physical disorder. Our results indicate that MUPS should at least be a secondary diagnosis, and when the MUPS hamper the RTW process, the guidelines for the management of MUPS should be applied. Sick-listed employees are severely bothered by their symptoms, and often agree to discuss mental causes. Explanations and reassurance are important, because the employees are seriously bothered by their symptoms. Older employees and employees working organizations with many cases of MUPS need extra attention, and their organizations should make extra efforts to strengthen their policy with regard to the management of sickness absence.

Psychiatric consultation is an interesting option in occupational health care, because it could help OHPs who have a good recognition of mental disorders but lack the specific knowledge to distinguish between severe MUPS, adjustment disorders and psychiatric morbidity. Our data and the results of other studies show that employees with severe MUPS are probably a blind spot for OHPs. Training OHPs in the diagnosis and treatment of severe MUPS according to the guidelines, the use of validated questionnaires, and a collaborative care setting will fulfill the most important needs of OHPs with regard to the management of employees with severe MUPS

